to permit the original surgeon to do secondary surgery, although, because of her poor financial circumstances the surgeon offered to do this surgery gratuitously.

CASE 2.—On a dark night an automobilist was endeavoring to push his stalled car off the highway. Another car struck him, catching his legs between the two bumpers. The result: compound comminuted fractures of both bones of both legs just below the knees, with great soft tissue damage and massive hemorrhage. When this patient was admitted to the hospital he was in severe shock, and in a critical condition. His care, even from hind-sight point of view, was splendid. One month later, both legs being in casts, x-rays showing good position and alignment, the patient insisted on leaving the hospital. This he did against his physician's advice. The patient was given instructions in writing to return to the out-patient clinic for further observation and treatment.

The patient did not return to the original physician. He consulted another physician. The second physician never contacted the first physician, or asked to see the several x-ray films which had been made. He did remove and reapply the casts. Later when it became apparent that there was non-union of the fracture of one tibia, the second physician imputed the responsibility therefor to the unskilled and negligent care of the first physician. As the result, suit was filed.

CASE 3.—An employed young woman developed a skin eruption. The physician, to whom she was sent by her employer, made a diagnosis of neuro-dermatitis. Her treatment included the use of a quartz lamp, but no x-ray. The patient, dissatisfied with her progress, consulted another physician, here designated as physician No. 2. Physician No. 2 sent the patient to a dermatologist. This specialist also made a diagnosis of neurodermatitis, and further reported that there was no evidence of radiation injury. Following this, physician No. 2 made a report to an insurance carrier on behalf of the patient. In this report he stated that she had sustained a third degree x-ray burn. He also wrote a letter to the patient's attorney incorporating this same statement. Suit has been filed against the original physician.

CASE 4.—A young woman, pregnant for the first time, began to have bright red vaginal bleeding during the third trimester of her gestation. The bleeding was not accompanied by pain. A diagnosis was made of placenta praevia. X-ray disclosed twin pregnancy with double breech presentation. She was kept in bed most of the time for several weeks, and the bleeding was well controlled. During this period she was twice admitted to hospital when the bleeding became more threatening. The periods of hospitalization covered about two weeks. Two days after her second stay in the hospital the patient went into active labor and hemorrhage became progressively worse. A consultant was called in and it was decided to do a Caesarian section. A low segment type of Caesarian was done. The patient developed a severe post-partum infection. The treatment she received was excellent and, all things considered, the patient did very well.

The patient's family were distressed by all these difficulties and worried because of expense. About two weeks after the delivery, the patient was removed from the hospital and placed under the care of a second physician. She was transferred to a second hospital. This was done without the prior knowledge of the first physician.

Suit is now threatened against the first physician. In a case such as this, very little incitation is necessary. It is believed that the threat to sue is due to the attitude and the remarks of the second physician. Whether the matter goes on to actual suit apparently depends entirely on him. The second physician has now been placed in posession of all the facts of the case. He might have had the full facts at any time had he sought them. If now he indulges only in fair comment, there probably will be no suit.

IN CONCLUSION

If an economic recession follows our war prosperity, it must be apprehended that there may be a marked increase in the number of malpractice claims.

Since it is physicians who start malpractice cases, it is certain that there will be a sharp decrease in malpractice incidence when physicians, themselves, stop instigating unjust malpractice suits. Whenever a bad result case is presented to any physician, that physician must insist upon being put in possession of *all* of the facts of the case before he permits himself to condemn the professional care previously rendered to that patient.

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PREPAID MEDICAL SERVICE PLANNING*

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At the present time considerable attention is being devoted to Prepaid Medical Service Planning, which is reviewed in this article in terms of the patient, family physician, and legislator.

Certain principles of medical care as applied to distribution and cost are also evaluated in relation to our American Way of Life. Prepaid medical service planning appears to be necessary for the post-war era. What future course to follow in this all-absorbing phase of health preservation is left to the judgment of the reader.

CONTENTS

Introduction

THIS article has been prepared as a condensed review of what appears to be a realistic approach to prepaid medical service planning.

The various views expressed may perhaps be of interest to patients, employers, physicians, and legislators, whether on a local, state, or federal basis.

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† For ease in reference, queries have been given numbers by Editor of CALIFORNIA AND WESTERN MEDICINE.

I—Orientation†

1—What kind of medical care is wanted?
It is self-evident that every American wants the **best medical service possible.**

2—Is this attainable?
America is the one country that has the **essential facilities** for offering the best medical service possible.

3—Why is this true?
Because American ingenuity and foresight have seen fit through voluntary and legislative means to support that type of medical practice, which has resulted in a system of medical care **unequaled in any other country in the world.**

4—Is this a priceless heritage?
Experience has shown, and statistics verify the contention that (1) life expectancy, (2) freedom from illness, (3) avoidance of premature death in this country, is an American heritage **which perhaps needs to be zealously safeguarded.**

5—Is this true in other countries?
Investigation and study apparently reveal that these same conditions **do not prevail in other countries.**

II—Medical Leadership

6—What is the reason for this American leadership?
America has been willing to accept the premise that all features of medical service, in any method of medical practice, of necessity needs to be under the immediate guidance of the medical profession.

7—Is this basic?
Apparently, because no other individual, or groups of individuals, are educationally equipped and qualified to exercise impartially this guidance and supervision.

III—Patient Coöperation

8—Is this true in terms of patients seeking medical care?
Just a little thought suggests the wisdom of not permitting any third person, or organization, **to come between the patient and his physician** in any medical relation.

9—What about responsibility?
In all fairness, it perhaps can be conceded that responsibility for the character of medical service can be borne by the profession with "advantage to all concerned."

10—Do patients desire to choose their own doctor?
Patients, in order to get well, need to be granted full latitude in choosing a legally qualified doctor of medicine, who will serve them among all those qualified to practice, and who is willing to give such service.

11—How do patients want medical service administered?
The method of giving medical service needs to be a permament **confidential** matter between the patient and a "family physician" if that patient is to be satisfied, protected, and given hope for early recovery.

12—Is this essential?
In order to be successful, it is highly essential that this relation be the fundamental and dominating feature of any medical service plan.

IV—The Cost of Medical Service

13—What about the cost of medical service?
In whatever way the cost of medical service is distributed, it of necessity needs to be paid for by the patient **in accordance with his income status,** and in a manner that is mutually satisfactory between the patient and family physician.

14—What about "cash benefits"?
Medical service need not, and must have no connection, with any cash benefits.

15—Are medical costs excessive in America?
To be realistic on this point, **the answer is yes,** similar to other costs in business, manufacturing, building a home, and educating children.

16—What can be done about it?
As in other fields, plans and preparations are being formulated to meet these costs on a prepayment basis.

17—How can this be done?
Through **prepaid medical service planning,** as in other fields of post-war planning.

18—Is this being done?
Yes, the American public at long last has come to realize that prepayment plans for medical service are as basic as any other planning to meet unanticipated emergencies.

19—Can full coverage be obtained?
Like any other assurance against the unexpected, insurance coverage against unexpected medical emergencies can, because of actuarial experience, be obtained on a **partial coverage basis only.**

V—Regarding Medical Institutions

20—What about the operation of medical institutions?
To be successful, which is the desire of the American public, it is highly essential that the medical phases **of all institutions** involved in medical service be under professional medical guidance and supervision.

21—Does this include all phases of hospitalization?
It should be clearly understood that **hospital service** and **medical service** are two distinct entities, and each requires separate consideration.

22—What are "medical service" institutions?
Medical service institutions, whether they function under the name of a hospital or some other name, are but expansions of the equipment of the "family physician."

23—What is the basis for this contention?
The family physician is the only one whom **the laws of all nations** recognize as competent to use these institutions in the furnishing of adequate medical service.

VI—Evaluation of These Institutions

24—Who can determine the adequacy of such institutions?
The medical profession, because of its unique, ultra scientific basic training in human illness, **is particularly fitted** to determine the adequacy and character of medical service in institutions.

25—Upon what does the value of these institutions depend?
The value of all medical institutions depends primarily on their operation according to **accepted medical standards.**

VII—What About Doctors?

26—What about the "all inclusiveness" of medical service?
Medical service in any and all forms, of neces-

sity, need to include within it's scope, **all legally qualified doctors of medicine** of the locality covered by its operation, who wish to give service **under accepted standards** of operation. This is basic as in every other type of business.

27—What medical service restrictions are undesirable to American patients?

There should be no restrictions on (1) **treatment,** or (2) **prescribing,** not formulated and guided **by the medical profession.**

28—Why is this apparently true?

The quickest way to afford the American people with **inferior medical service,** so prevalent in all too many other countries, is to allow a third person, whether he represents an individual, corporate body, organization, or civic authority, to place restrictions on (1) medical treatment, or (2) prescribing, which today can gain headway unless the **stop signal of "caution"** is observed.

29—Is there proof of this contention?

Inability to carry out an accepted method of treatment, or failure to obtain an accepted medicine, vaccine, or serum for patients, because of lay adopted rules and regulations promulgated **without medical guidance** seriously handicaps a patient in getting well.

30—Is this very prevalent at the present time?

Fortunately American ingenuity has seen fit to leave most of these problems up to the present time to the judgment of the family physician.

VIII—Medical Service to the Needy?

31—What about medical service to the needy?

Medical service systems for the relief of low income classes need to be limited strictly to those below the "comfort level" standard of incomes.

32—In what way does this apply?

Those able to pay should not share medical service of institutions designed primarily for those unable to pay.

33—Should the public assist in this regard?

Those unable to pay must of necessity have public consideration, as is the custom in this country today.

34—What about the low income or "white collar" group?

This is where the individual employer and insurance carrier can coöperate in solving a "common welfare problem."

35—Why has this not been done before?

Like all other emergency expenses, we all have not seen the wisdom of planning for what is called a "rainy day."

36—Should this be a matter of compulsion?

This is the problem for consideration. Its solution **rests with the people,** not the medical profession. The doctors can be relied upon for sound advice and counsel in this matter.

IX—Organizing Plans For Prepaid Medical Service

37—Is it a simple task to organize prepaid medical care plans?

It is not an easy, simple task to organize prepayment plans for medical care that

(1) will be **actuarially sound,**

(2) will not divert an inordinate amount of the income to **administration,**

(3) **will gain and hold the confidence** of the American public,

(4) secure the **wholehearted coöperation of all physicians,** and thereby permit a wide freedom of choice,

(5) contain within itself the necessary professional machinery which will assure all patients that **high standards of medical service** will be maintained.

X—Various Plans

37—Is this the reason for the many different prepayment plans?

The very fact that there are numerous different prepayment plans for medical service in the United States is a glowing tribute to the individual initiative of the American public.

39—What else does this indicate?

That the various people from the various diversified sections of the country **desire and want to preserve** local control and local administration of home affairs.

XI—Government Supervision

40—Can this become a state or federal function?

Medical service, like any other professional or business function, can become the province of a state or federal unit.

41—Is this what the American Public wants?

This is the question now confronting the thousands of existing and future patients in need of medical care in this country, who perhaps should be made aware of the threat to our American system of medical practice.

XII—Who Will Decide?

42—What is the answer?

The answer rests solely and only with the desires and wishes of patients themselves, and not with the family physician.

43—Why is this true?

Because the family physician cannot legislate—he is only the servant of his patients. He can only advise.

44—What will the physician do in this matter?

He will abide by the wishes and desires of the patient, who must choose what type of medical service distribution is wanted in this country.

45—What is the basis of this contention?

The family physician, through training, obligation to his patients, and attention to the arduous task of rendering adequate medical service to the sick is too busy to undertake the task of deciding what type of medical service distribution the American public wants.

46—Does he know what medical service is wanted?

Yes, he is overly conscious of the fact that all patients desire and hope for the best medical service possible.

XIII—Which System Is The Best?

47—Is Medical Service under government supervision the best?

This is what the American public has to decide—not the family physician—because he has no control over the matter. This is an important point, that perhaps should not be forgotten.

48—Which would be the best for the doctor?

Statistics show that the family physician, by and large, takes less interest in legislative matters than any other professional man. His aim is to serve humanity according to the medical facilities placed in his hands for service.

49—Why is this?
Because the very nature of his professional calling requires an approach, understanding, and consideration of people, not found in any other profession; **people when sick require a highly specialized method of approach.**

50—Is the practice of medicine a public matter?
Ask any patient or doctor and it will soon be learned that the practice of medicine needs to be one of the most confidential matters between the one being treated and the physician of the patient's own choice.

51—Is this the way the public wants it?
This is a matter for the American public to decide.

* * *

XIV—Governmental Control

52—Can governmental agencies carry on this function successfully?
No one really knows at the present time. There are many advocates of the present system and some favor the government entering this important phase of American existence.

53—What about the government system in other countries?
Nearly every foreign country has one system or another of governmentally supervised medical service.

54—Are they successful?
This depends upon
(1) what is considered "successful,"
(2) from what source the information is obtained,
(3) what constitutes adequate medical service.
The sickness, premature death and baby death rates in other countries are, however, quite different from the **prevailing low rates** in this country.

55—Are there many advocates of this system?
From an economic standpoint, all Americans are by nature endowed with an innate desire to have any agency, no matter what its origin, assure adequate medical service on a prepayment plan basis, whether sponsored by voluntary or official agencies, providing the medical service rendered is of **high quality and administered in a kindly manner.** These latter conditions are of supreme importance.

56—The matter then appears to be very simple?
With one exception perhaps, each patient, no matter his financial status, wants the best medical care possible when sick or near the "door of death."

57—Is this basic?
We will let you, Mr. Reader, be the judge.

* * *

XV—Voluntary Prepayment Plans

58—How do voluntary prepayment plans operate?
There are many voluntary prepayment plans for medical service in this country at the present time.

59—How many kinds are there?
In general, it perhaps may be said that there are
(1) commercial,
(2) nonprofit,
(3) employer or organization subsidized plans, of prepaid medical service in this country.

60—How many people today are covered with these plans?
It has been reported that over twenty-three million people are covered with these plans.

61—Have they been used very long in this country?
The **commercial or insurance plans** have been available for years; the **nonprofit plans** are of more recent origin; and the **employer subsidized plans** have been in existence for a number of years.

62—Do they cover all types of medical service?
No two of these plans are alike:
(1) some are limited in their coverage,
(2) a few provide full coverage, and
(3) others are very selective as to benefits.

63—Why is this?
Because the actuarial experience involved in sickness coverage through the "group plan" method has not been fully worked out as yet. It is well, perhaps, to remember that prepaid plans for medical service, of necessity, need to be on a **partial basis only,** like all other protection against fire, auto collision, and floods, if the premium cost is to be kept at a low figure.

64—What is meant by "employer subsidized plans?"
Many employers are uniting with employees to solve a "mutual welfare problem" by paying: (1) part, (2) half, (3) in some cases the entire premium cost of these plans.

65—Is this a good policy?
Time will tell. So far it appears that this procedure is beneficial in solving a **mutual problem.**

* * *

Comments Concerning Illinois Plans

* * *

XVI—One Voluntary Plan (in Illinois)

66—Can one of the voluntary plans be described?
In one county in Illinois, the local medical profession has formulated a plan which for illustration will be described.

67—What is the cost of this plan?
The cost of this voluntary prepayment plan for medical services only is as follows:
$1.00 per month for a single man, or $12.00 a year
$1.25 per month for a single woman, or 15.00 a year
$3.00 per month for a man and wife and all children between 3 months and 18 years of age, or $36.00 a year. It is also of interest that these amounts are reduced by 10 per cent when paid on an annual basis, which reduces the above amounts to $10.80, $13.50 and $32.40 respectively.

68—Can anyone take out this insurance?
For actuarial reasons, it is sold on the basis of not less than ten policyholders per group. (Any one desiring to carry Accident and Health indemnity coverage, however, at a minimum of $1.00 extra per month, may obtain this plan on an individual basis.)

69—Why is this?
There is no magical way to pay for medical service coverage; the well must help pay for the sick; there is no other way to pay the bill.

* * *

XVII—Coverage (In Illinois)

70—What medical services are included in this plan?
A fee of $2.00 per call in the event of any disabling illness; (1) on the part of a single man or woman up to 65 years of age, (2) on the part of husband or wife up to 65 years of age, (3) any dependent between 3 months and 18 years,

(4) the fee is paid regardless of whether the call is made in a physician's office, in a hospital, or in a patient's home, (5) the first two calls per person are deducted which must be paid by the patient, (6) in the event of a surgical disability payment begins **with the first call.**

71—Does this mean that disabling illnesses are included?

Yes, disabling illnesses, with some few exceptions are included in the plan, after the first two visits to or by the family physician as previously stated.

72—Why are the first two calls not covered?

This no doubt can be done, but the premium cost, of necessity, would have to be raised. Therefore the first two doctor calls for the present are not included. The plan aims to provide an easy prepayment method of partially meeting the expense of **prolonged illnesses.**

73—What diseases and accidents are not covered?

Venereal diseases, mental diseases, and accidents or sicknesses covered by "workmen's compensation laws" are not covered.

74—Are physical examinations and diagnostic procedures included?

These procedures are not covered at present; they may be at a later date.

75—Are surgical operations and maternity covered in the plan?

Yes, these conditions are covered, and although the maternity fee is only $30.00 for the present, this may be raised at a later date.

76—What about the total amount of insurance paid?

(1) The total amount paid for any one illness for a single person or any one member of a family is up to $250 in any one year, (2) the total for all children is up to $500 in any one year, (3) the total for husband and wife is up to $500 in any one year, (4) in lieu of the $2.00 per call, the patient may elect to take a flat surgical fee as enumerated in the plan.

77—To whom is this money paid?

To the patient, which aids materially in meeting prolonged emergency medical costs. The patient pays the doctor. It is not intended that this plan shall cover the entire bill of the doctor.

78—Does the plan cover hospital expenses?

Not in Winnebago County, because this is covered by a "Blue Cross" **prepaid hospitalization plan.**

* * *

XVIII—Combined Medical Service and Hospitalization Cost (In Illinois)

79—In simple terms, then, what is the total medical and hospitalization cost?

(1) For a single man $1.00 plus hospitalization at 65c, or $1.65 times 12 months equals $19.80 per year, (2) for a single woman $1.25 plus hospitalization at 65c, or $1.90 times 12 months equals $22.80 per year, (3) for a husband, wife and children $3.00 plus hospitalization at $1.30, or $4.30 times 12 months equals $51.60 per year per family. See previous statement on the 10 per cent reduction when the medical care phase of this plan is paid annually, which reduces the above amounts to $18.60, $21.30 and $47.00 respectively.

80—Are the two plans described sold together?

No, the two plans are sold separately because they are handled by two different organizations. At a later date the Northern Illinois "Blue Cross" hospitalization organization may sell both these plans **on a group basis.** This, however, requires a change in the present state law (of Illinois), which no doubt will be done this year.

81—Are these premiums excessive?

Under the contemplated government compulsory plan, the premium is to be 3 per cent on all incomes up to $3,000; which, if a person earns $2.000, would equal $60.00 per year, so it can be seen that the plans described are much less as far as costs are concerned.

82—How can employers assist in this program?

In some communities, businessmen and industrialists have deemed it advisable to coöperate with employees by partially subsidizing the premium cost of this **mutual welfare problem.**

* * *

XIX—In Retrospect

83—1. An attempt has been made to evaluate prepaid medical service planning in the United States.

2. Due consideration has been given to the voluntary and compulsory saving aspects of this all-absorbing means of meeting emergency medical care expense.

3. That planning can assume either of these two courses is self-evident from data presented.

4. One plan recently inaugurated in Winnbago County, Illinois, covering both surgical and medical service, together with detail costs is presented outlining a more economical voluntary plan, which includes private insurance policies, and which permits anyone to choose his own physician.

5. This plan appears to be more satisfactory than the anticipated government plan, in which 3 per cent of all incomes up to $3,000 per year will be imposed and set aside to meet unanticipated surgical and sickness emergencies.

6. Many people prefer to have their own choice of physician.

7. Which of these two systems is the most desirable is left to the judgment of the reader.

City Hall Building.

"Of Mice, and Men and Women"

(Continued from Page 54)

SUMMARY

Our purpose has been to collate from diverse sources the positive findings regarding the association of estrogenic activity with the development of cancer of the female genital system. It would be a distortion of facts not to say that the positive findings cited represent a minor part of the incidence of the cancers discussed. Quantitative results as in animals cannot be expected in incidental human observations. However, the above cited data should be sufficient to overthrow complacency toward the evidence of animal experimentation with estrogens. It is hoped that these clues to the sequence and causality in the development of cancer in the female genital system will lead to more detailed clinical studies, and ultimately to a basic and better control of the malignant tumors of the breast and uterus.*

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* Bibliography furnished on request. (U. C. Med. School.)